

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 02/03/01, 10/29/01, and 11/06/01?
- b. The request was received on 01/23/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC-60
 - b. HCFAs
 - c. EOBs
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Based on Commission Rule 133.307 (g)(4) the Division notified the insurance carrier Austin Representative of their copy of the request on 04/04/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit 2 of the Commission's case file.
3. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: per the TWCC 60b,
"...we are due further reimbursement for the durable medical equipment we provided."
2. Respondent: No 14-day response received

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only dates of service eligible for review are 02/03/01, 10/29/01, and 11/06/01.
2. The carrier's EOB has the denial "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
02/03/01 10/29/01	L1080	\$400.00 \$400.00	\$295.55 \$295.55	M M	DOP DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011 (d), Rule 133.304 (i); MFG, GI (III) & (VI)	Due to the fact there is no current fee guideline for the DME provided, the Medical Review Division has to determine based on the parties' submission of information, what represents fair and reasonable reimbursement. The MFG, GI (III) states, "(DOP) in the ...(MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill." This places the burden on the provider to show what is fair and reasonable reimbursement. Even though the carrier has not submitted a response to the request for dispute resolution, the issue per the EOB is fair and reasonable reimbursement. The provider has not submitted reimbursement data to show that their billed amount is fair and reasonable per MFG, GI (III). Therefore, no additional reimbursement is recommended.
10/29/01	E0748-NU	\$5000.00	\$3342.55	M	DOP	See above	See above
11/06/01	E1399	\$239.00	\$55.00	M	DOP	See above	See above
Totals		\$6039.00	\$3988.65				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 21st day of May, 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.